

161 M
FOR STATE
HEALTH DEPT.

10 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

10 FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14188

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14188

1. PLACE OF DEATH a. COUNTY Garrett b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE W. Va. b. COUNTY Kanawa	
c. LENGTH OF STAY IN lb 1 hr. 35 min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ru ral - Charleston	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Garrett County Memorial Hospital		d. STREET ADDRESS Route #1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First William	Middle Thomas	Last Akers
4. DATE OF DEATH October 23rd.	Month	Day	Year 19 66
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-24-1917
9. AGE (In years last birthday) 49 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Sheet Metal Worker	10b. KIND OF BUSINESS OR INDUSTRY Building	11. BIRTHPLACE (State or foreign country) Raleigh Co., W. Va.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME William F. Akers	14. MOTHER'S MAIDEN NAME Lillian Kirk		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 235-26-5089	17. INFORMANT William G. Akers, (Son)	Address Charleston, W. Va.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis			INTERVAL BETWEEN ONSET AND DEATH Hours
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Coronary sclerosis stating the underlying cause (c)			Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Previous myocardial injury			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)	20f. (City or town) Oakland (County) W. Va. (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Noturol causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>James H. Feaster, Jr., M.D.</i>	CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED 10-23-66
EXAMINER'S NAME (Type) James H. Feaster, Jr., M. D.	Address (Street, city, town, or county) Oakland, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/25/66	23c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park	23d. LOCATION (City or Town) South Charleston (County) W. Va. (State)
24. FUNERAL DIRECTOR John O. Durst LEIGHTON-DURST FUNERAL HOME, Oakland, Md.	ADDRESS <i>John O. Durst</i>	25a. REC'D BY REGISTRAR Oct 28 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

1 To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

2 To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14189 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH 14189

1. PLACE OF DEATH a. COUNTY Garrett		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b 4 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Garrett County Memorial Hospital		e. STREET ADDRESS Bittinger	
65		f. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Clarence		First Brenneman	Middle Brenneman
4. DATE OF DEATH October 24 1966		5. SEX Male	6. COLOR OR RACE White
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 2-8-82	
9. AGE (In years last birthday) 84 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED CARPENTER	
10b. KIND OF BUSINESS OR INDUSTRY SELF-EMPLOYED		11. BIRTHPLACE (County & State, or foreign country) Bittinger, Maryland	
12. CITIZEN OF WHAT COUNTRY? America		13. FATHER'S NAME Joel J. Brenneman	
14. MOTHER'S MAIDEN NAME Katherine Bittinger		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) —	
16. SOCIAL SECURITY NO. —		17. INFORMANT Frank Brenneman, Bittinger	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X		INTERVAL BETWEEN ONSET AND DEATH 10 days	
DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) ADVANCED CEREBRAL ARTERY SCLEROSIS			
DUE TO (c) —			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —
20f. (City or town) Oakland, Maryland		(County) —	
(State) —		21. I certify that (I) this hospital attended the deceased from October 20, 1966 , to October 24, 1966 , that (I) was last saw the deceased alive on October 24, 1966 , and that death occurred at 1:35 P.M. from the causes and on the date stated above.	
22a. SIGNATURE B. Baumgartner		22b. DATE SIGNED 10/24/66	
22c. PHYSICIAN'S NAME (Type) Dr. E. I. Baumgartner		22d. ADDRESS Oakland, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/27/66	
23c. NAME OF CEMETERY OR CREMATORIAL BITTINGER		23d. LOCATION (City, town or county) BITTINGER GARRETT CO. MD	
24. FUNERAL DIRECTOR Don Newman, Grantsville, Md.		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Charles Judge	
ADDRESS —		DATE OCT 31 1966	

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FOR STATE
HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14190

14190

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PN3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 4 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours of death.

1. PLACE OF DEATH o. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Garrett				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Deer Park		c. LENGTH OF STAY IN 1b Lifetime				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS Deer Park				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) MARTIN		First VAN	Middle BROWNING			
4. DATE OF DEATH Month October Day 30 , Year 1966	Month October	Day 30	Year 1966			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 6, 1904			
9. AGE (In years last birthday) 62 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Junk Dealer	11. BIRTHPLACE (State or foreign country) Deer Park, Maryland	12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Samuel S. Browning	14. MOTHER'S MAIDEN NAME Anna M. Grimm	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				
16. SOCIAL SECURITY NO. 212-16-0439		17. INFORMANT Mrs. M.V. Browning, Deer Park, Md.	Address (Widow)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 4201 DUE TO Arteriosclerosis, generalized Years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Sudden				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Oakland, Md.	(County) Oakland, Md.	(State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.		22. DATE SIGNED 10-31-66		
EXAMINER'S NAME (Type) James H. Feaster, Jr., M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Oakland, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/2/66	23c. NAME OF CEMETERY OR CREMATORIAL Deer Park Cemetery	23d. LOCATION (City or Town) Deer Park	(County) Maryland	(State) Md.
24. FUNERAL DIRECTOR John O. Durst		ADDRESS Leighton-Durst Funeral Home, Oakland, Md.	25a. REC'D BY REGISTRAR NOV 2 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

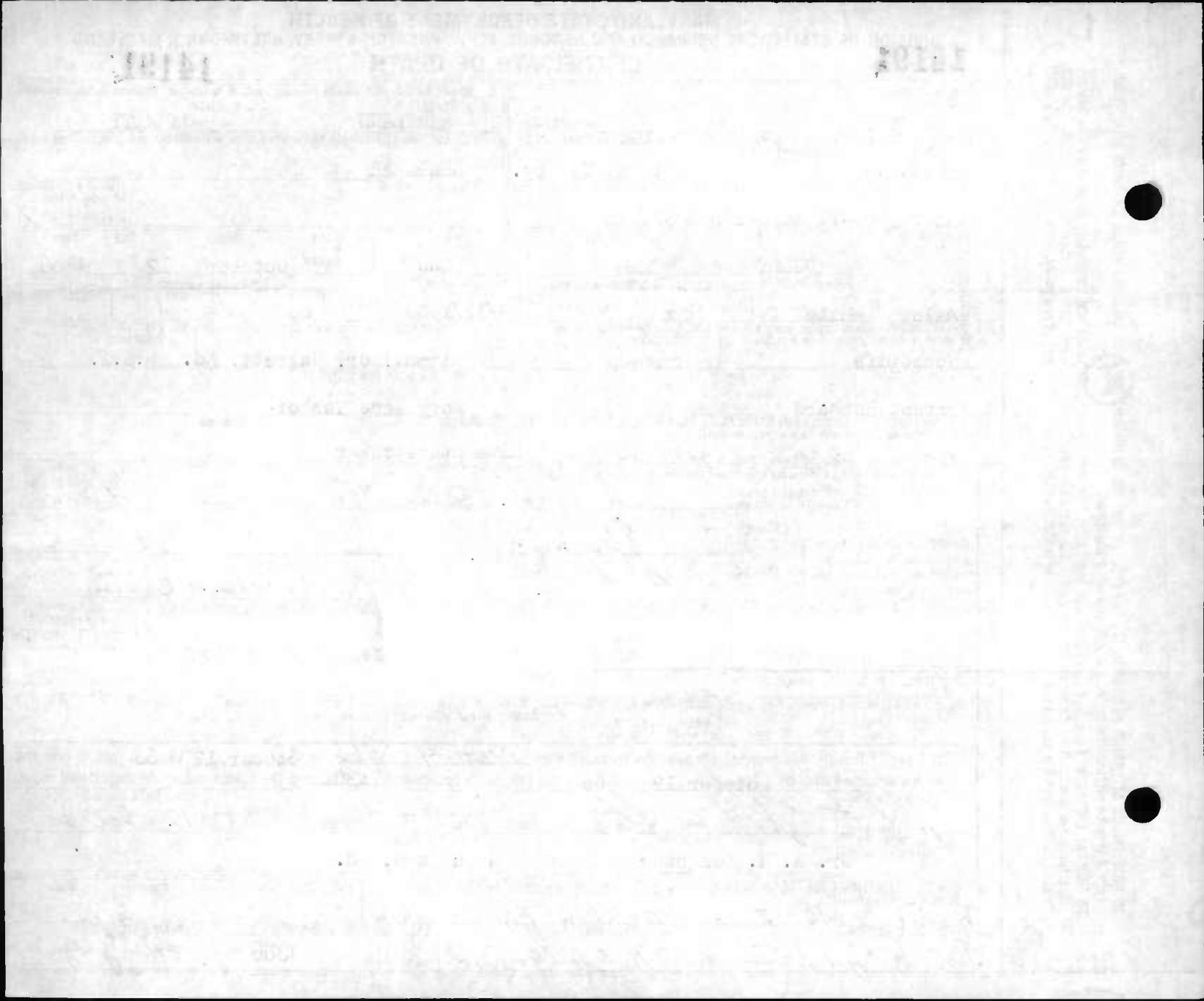
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14191
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH
14191

1. PLACE OF DEATH a. COUNTY GARRETT		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN 1b 1 Day 21 Hrs.		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY GARRETT	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GARRETT COUNTY MEMORIAL HOSPITAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SHALLMAR		d. STREET ADDRESS 11-1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First DOLLY	Middle MAE	Last COON	4. DATE OF DEATH October 12 1966	Month October	Day 12	Year 1966		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 3/12/1900	9. AGE (in years last birthday) 66 yrs.	10. IF UNDER 1 YEAR Months 66	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	13. Months 0	14. Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Kitzmiller, Garrett, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Forrest Barnard		14. MOTHER'S MAIDEN NAME Mary Jane Tasker		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-52-9783		17. INFORMANT Elva Stonebraker	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4221		DUE TO Uremia		Cerebral Vascular Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 4 days			
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. Arteriosclerotic Cardio Vascular Disease		DUE TO Arteriosclerotic Cardio Vascular Disease		Unknown		1 week			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Oct 9 1966 to October 12 1966 , that (I) (we) last saw the deceased alive on October 12 1966 , and that death occurred at 7:30 AM from the causes and on the date stated above.		22a. SIGNATURE Robert H. Leighton							
22c. PHYSICIAN'S NAME (Type) Dr. H. H. Leighton		22b. DATE SIGNED 12 Oct 66							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-15-66		23c. NAME OF CEMETERY OR CREMATORY Heckler Hill Cemetery		23d. LOCATION (City, town or county) (State) Elk Garden W Va			
24. FUNERAL DIRECTOR Robert Kyle Britta Jr.		ADDRESS Kitzmiller, Md.		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge			
VR A15 (4) 15M 4-64		DATE OCT 17 1966							



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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14192

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14192

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PM3. Page 5 may be retained for your files.

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1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b 40 minutes	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Garrett County Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles First Woodrow Middle Davy		4. DATE OF DEATH October 20 1966	
5. SEX Male 6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH Oct. 30, 1912 9. AGE (In years lost birthday) 53 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipe Fitter		10b. KIND OF BUSINESS OR INDUSTRY Plumbing 11. BIRTHPLACE (State or foreign country) Hampshire Co., W. Va. 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles A. Davy		14. MOTHER'S MAIDEN NAME Rosa L. Shears	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 705-05-9327 17. INFORMANT Mrs. Viola Davy see #2 above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis, acute		INTERVAL BETWEEN ONSET AND DEATH Hours	
4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Doy, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) Oakland (County) Maryland (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>James H. Feaster, Jr., M.D.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) James H. Feaster, Jr., M. D.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/22/66 23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Oakland Cemetery	
23d. LOCATION (City or Town) Oakland (County) Maryland (State)		23e. REG'D BY REGISTRAR OCT 24 1966 23f. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
24. FUNERAL DIRECTOR <i>Gerald J. Minnick</i>		25a. ADDRESS Oakland, Maryland 25b. DATE OCT 24 1966	

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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14193

CERTIFICATE OF DEATH

14193

Item #1d Film #6332 10/20/66 PG

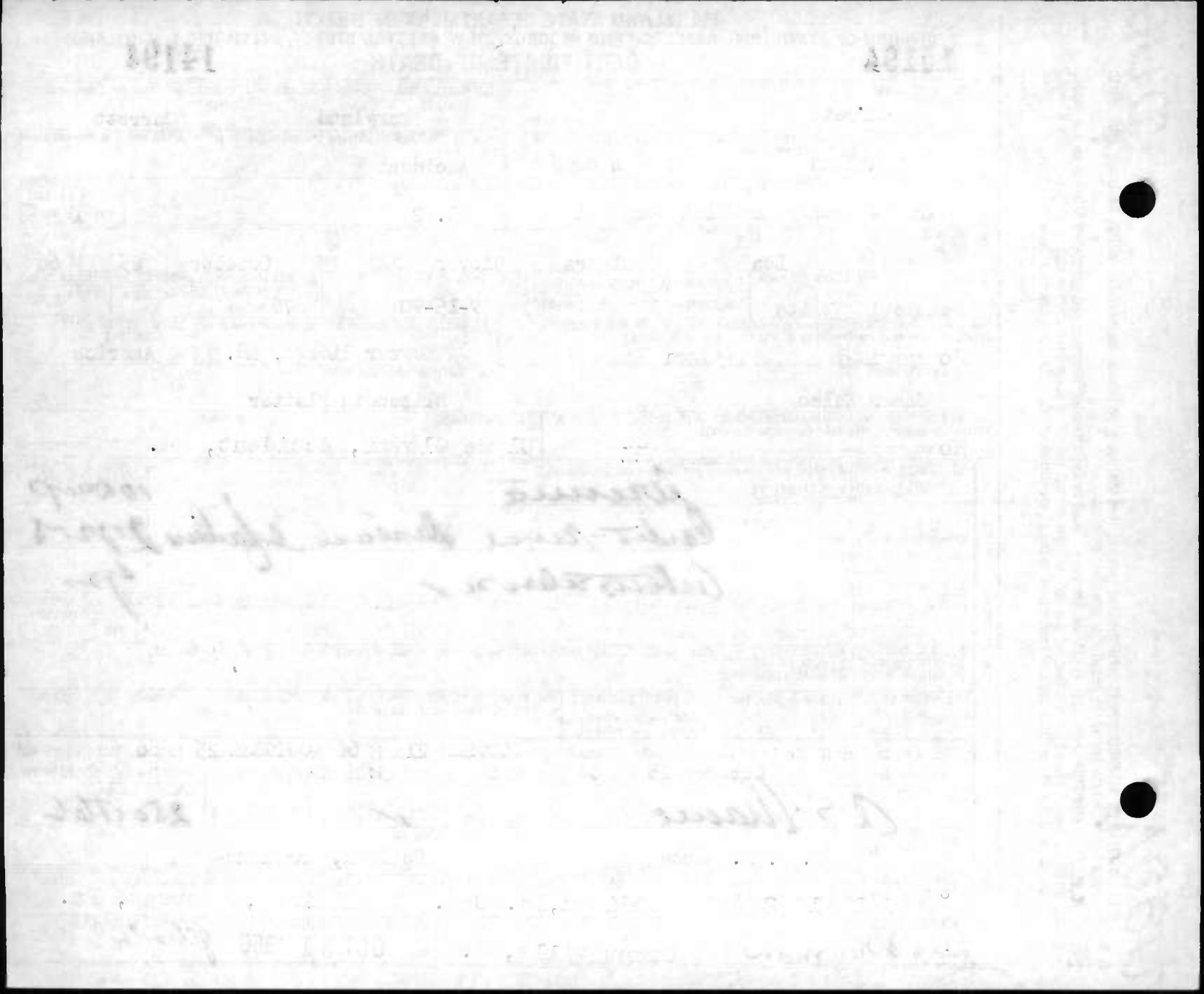
1. PLACE OF DEATH a. COUNTY	Garrett MARYLAND			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE b. COUNTY	Md. Garrett		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Grantsville			c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)	Star Route (home of Daughter)			d. STREET ADDRESS	Grantsville		
13. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. UNDER 1 YEAR	11. UNDER 24 HRS.	
F	W	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Jan. 28, 1876	90 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?				
Housewife	Own Home	Bromsgrove, England	XXXXXX USA				
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME						
Benjamin Lidell Emily Collins							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address				
no	---	Mrs. Grace Garlitz, Grantsville, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> INTERVAL BETWEEN DUE TO <i>4201</i> ONSET AND DEATH <i>Immediate</i>							
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary Atherosclerosis</i> <i>sw. years</i>							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Cerebral Atherosclerosis</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
19							
21. I certify that (I) (this hospital) attended the deceased from <i>Sept</i> , 1962, to <i>Oct 6</i> , 1966, that (I) (we) last saw the deceased alive on <i>Sept 26 1966</i> , and that death occurred at <i>1001 M</i> , from the causes and on the date stated above.							
22a. SIGNATURE <i>Paul E. Berkebile</i>							
22b. DATE SIGNED <i>10/8/66</i>							
22c. PHYSICIAN'S NAME (Type) <i>PAUL E. BERKEBILE MD.</i> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>							
22d. ADDRESS <i>349 MAIN ST, MEYERSDALE, Pa.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/9/66	23c. NAME OF CEMETERY OR CREMATORIAL St. Paul Church Cem.	23d. LOCATION (City, town or county) R.D., Meyersdale, Somerset,	(State) Pa.		
24. FUNERAL DIRECTOR <i>Ruth E. Newman</i> ADDRESS Grantsville, Md.							
25a. REC'D BY REGISTRAR DATE OCT 11 1966 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>							

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit, then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
14194 CERTIFICATE OF DEATH 14194											
1. PLACE OF DEATH a. COUNTY Garrett MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland			c. LENGTH OF STAY IN 1b 4 Days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Accident			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Garrett County Memorial Hospital						d. STREET ADDRESS Rt. 2					
3. NAME OF DECEASED (Type or print)		First Loa	Middle Elnora	Last Glover	4. DATE OF DEATH October 25 1966	Month October	Day 25	Year 1966			
5. SEX Female		6. COLOR OR RACE White	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED	8. DATE OF BIRTH 9-15-90	9. AGE (In years last birthday) 76 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. HOURS Hours 0	13. MIN. Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own Home			11. BIRTHPLACE (County & State, or foreign country) Keyser Ridge, Md.			12. CITIZEN OF WHAT COUNTRY? America		
13. FATHER'S NAME James Kelso						14. MOTHER'S MAIDEN NAME Elizabeth Platter					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. ---			17. INFORMANT Address Clyde Glover, Accident, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteria</i> 442 X DUE TO <i>Arteria</i> Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <i>Cardio-vascular Disease, failure 2 yrs</i> (c) <i>Arteriosclerosis</i> INTERVAL BETWEEN ONSET AND DEATH 10 days											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from OCTOBER 21, 1966, to OCTOBER 25, 1966, that (I) (we) last saw the deceased alive on October 25 1966, and that death occurred at 10 AM from the causes and on the date stated above.											
22a. SIGNATURE <i>A. E. Mance</i>						22b. DATE SIGNED M.D. ATTENDING MED. DIRECTOR STAFF PHYS. <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <i>25 Oct 66</i>					
22c. PHYSICIAN'S NAME (Type) Dr. A. E. Mance						22d. ADDRESS Oakland, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 10/28/66			23c. NAME OF CEMETERY OR CREMATORIAL Addison, Pa. Cem.			23d. LOCATION (City, town or county) (State) Addison, Somerset, Pa.		
24. FUNERAL DIRECTOR <i>Don J. Newman</i>						ADDRESS Grantsville, Md.					
25a. REC'D BY REGISTRAR DATE OCT 31 1966						25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



1
To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14195 14195

1. PLACE OF DEATH a. COUNTY GARRETT			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE WEST VIRGINIA		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND			b. COUNTY PRESTON		
c. LENGTH OF STAY IN 1b 4 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EGLON		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Garrett County Memorial Hospital			d. STREET ADDRESS Box 258		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First JAMES	Middle NELSON	Last HARSH	4. DATE OF DEATH October 4 1966	Month Day Year
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-12-82	9. AGE (in years last birthday) 84 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (County & State, or foreign country) PRESTON, WEST VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME LLOYD HARSH			14. MOTHER'S MAIDEN NAME MARY COHEN		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 232-10-3660		17. INFORMANT Mrs. Melvin R. Harsh - Daughter in Law	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 6000 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Wecchia</i> <i>Chronic Pseudoneuritis</i>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Oakland, Maryland	(County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10/1 1966 , to Oct. 4 1966 , that (I) (we) last saw the deceased alive on Oct. 4 1966 , and that death occurred 11:57 AM , from the causes and on the date stated above.					
22a. SIGNATURE <i>A. E. Mance</i>			22b. DATE SIGNED 5 Oct 66		
22c. PHYSICIAN'S NAME (Type) A. E. MANCE			22d. ADDRESS Oakland, Maryland		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/7/1866	23c. NAME OF CEMETERY OR CREMATORIUM Eglon Cemetery	23d. LOCATION (City, town or county) (State) Eglon, West Virginia	
24. FUNERAL DIRECTOR Charles L. Hinkle		ADDRESS <i>Charles L. Hinkle</i>		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
DATE OCT 10 1966					

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

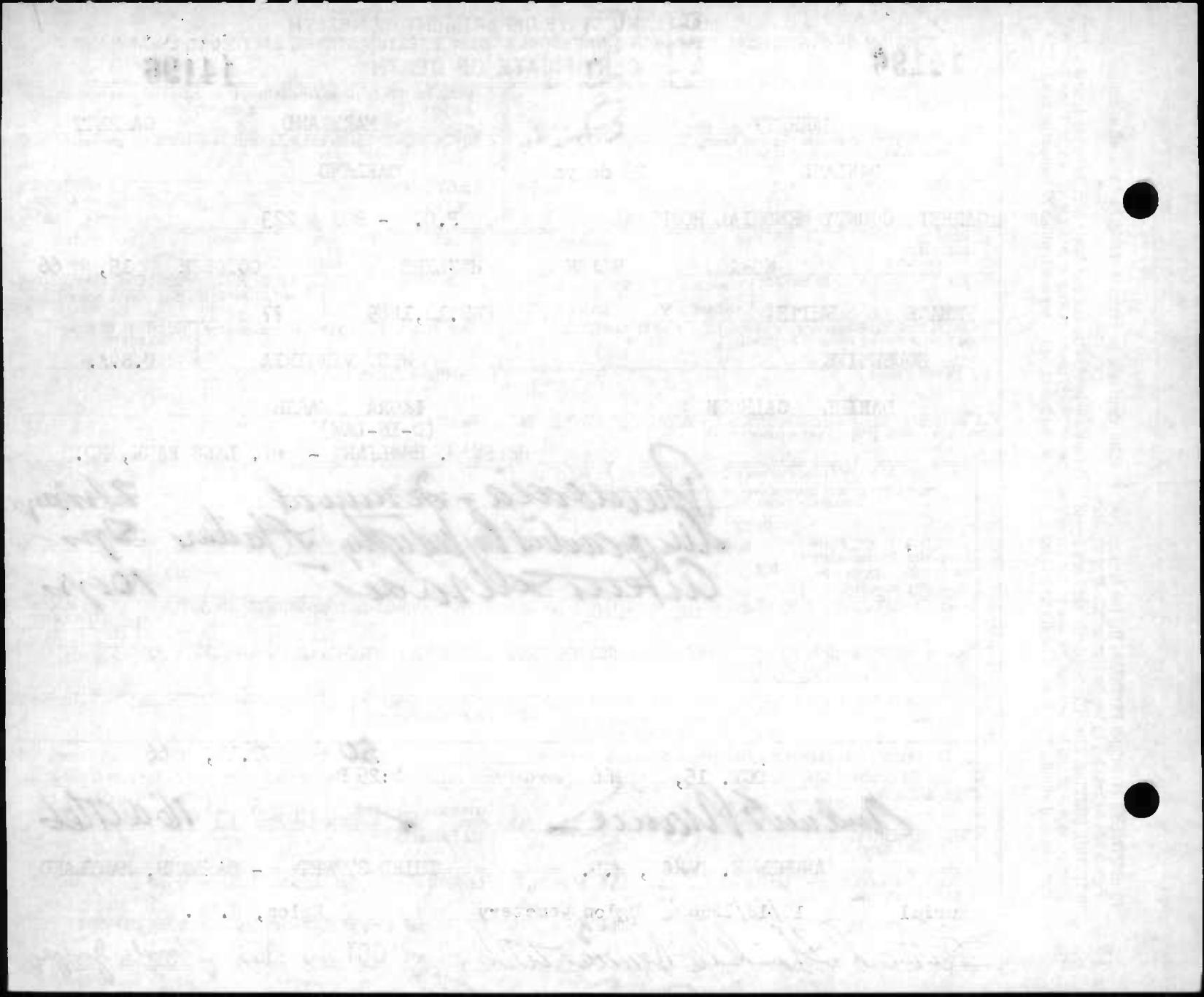
11 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14196

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE b. COUNTY MARYLAND GARRETT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN 1b 25 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GARRETT COUNTY MEMORIAL HOSPITAL		d. STREET ADDRESS P.O. - BOX # 223	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		e. DATE OF DEATH OCTOBER 15, 1966	
3. NAME OF DECEASED (Type or print) NORA		First MIDDLE ELLEN HENLINE	
4. LAST		5. SEX FEMALE	
6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH FEB. 14, 1889		9. AGE (In years last birthday) 77 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DANIEL CALHOUN		14. MOTHER'S MAIDEN NAME LAURA HARSH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT (D-IN-LAW) HELEN M. HENLINE		Address - MT. LAKE PARK, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4221 DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
INTERVAL BETWEEN DEATH AND DEATH 27 days Hypertension - cerebral hemorrhage & failure 5 yrs - After sellars - 10 yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>150</u> to <u>OCT. 15, 1966</u> , that (I) (we) last saw the deceased alive on <u>OCT. 15, 1966</u> , and that death occurred <u>4:25 PM</u> , from the causes and on the date stated above.		22b. DATE SIGNED 16 Oct 66	
22a. SIGNATURE <u>Andrew E. Mance</u>		22c. ATTENDING M.D. PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) ANDREW E. MANCE, M.D.		22d. ADDRESS THIRD STREET - OAKLAND, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/18/1966	
23c. NAME OF CEMETERY OR CREMATORY Eglon Cemetery		23d. LOCATION (City, town or county) (State) Eglon, W. Va.	
24. FUNERAL DIRECTOR Lester P. Hinkle Davis & Walker		25a. REC'D BY REGISTRAR DATE OCT 20 1966	
ADDRESS		25b. REGISTRAR'S SIGNATURE Charles Judge	



1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14197

14197

PLACE OF DEATH o. COUNTY Garrett MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give near Oakland		c. LENGTH OF STAY IN 1b 11 Mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Week's Nursing Home			d. STREET ADDRESS Maryland Ave.		
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Paul	Middle Audrey	4. DATE OF DEATH Oct.	Month 6	Day Year 1966
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 13, 1884	9. AGE (In years lost 82 month/day yrs.)	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic			10b. KIND OF BUSINESS OR INDUSTRY Own. Home	11. BIRTHPLACE (State or foreign country) W. Va.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Oliver Kight			14. MOTHER'S MAIDEN NAME Elmira Barricks		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Melvin Moorehead	1377 Cornell St. Keyser, W. Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>Myocardial infarction</i> DUE TO <i>Arteriosclerosis</i> INTERVAL BETWEEN ONSET AND DEATH <i>hr.</i> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <i>Angina pectoris</i> (c) <i>Emphysema</i> DUE TO <i>Arteriosclerosis</i> <i>mos</i> Years.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Anemia</i> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Oakland, Md.	(County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>Oct. 6</i> , 19, to <i>Oct. 6</i> , 19, that (I) (we) last saw the deceased alive on <i>Oct. 6</i> , 19, and that death occurred at <i>6 p.m.</i> from the causes and on the date stated above.					
22a. SIGNATURE <i>B. L. Grant M.D.</i>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 1966	
22c. PHYSICIAN'S NAME (Type) <i>B. L. Grant M.D.</i>			22d. ADDRESS Oakland, Md.		
23a. BURIAL, CREMATION, Buryal (Specify)		23b. DATE THEREOF Oct. 9, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Philos Cem.	23d. LOCATION (City, town, or county) Westernport, Md. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Elmer</i>			ADDRESS Westernport, Md.	25a. REC'D BY REGISTRAR DATE OCT 10 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1 M

14198

CERTIFICATE OF DEATH

14198

10 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
 10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Oakland		c. LENGTH OF STAY IN 1b 46 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route #1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) RUSSELL HARLAND		First Middle LEIGHTON	4. DATE OF DEATH Month October Day 24, 1966
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Dealer		8. DATE OF BIRTH June 23, 1900	
10b. KIND OF BUSINESS OR INDUSTRY Auto Garage		9. AGE (In years last birthday) 66 yrs.	
10c. BIRTHPLACE (County & State, or foreign country) Garrett Co., Maryland		11. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME R. Oliver Leighton		14. MOTHER'S MAIDEN NAME Laura Sines	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-32-8260	
17. INFORMANT		Address (widow) Mrs. Laura Leighton, Ft 1, Oakland, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) DUE TO (c) DUE TO		Acute Pulmonary Edema Acute Myocardial Infarct Arteriosclerotic Cardio Vascular Disease Unknown INTERVAL BETWEEN ONSET AND DEATH 20 minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June, 1959 to Oct 24, 1966, that (I) (we) last saw the deceased alive on Oct 16, 1966, and that death occurred at 7:15 A.M. from causes and on the date stated above.		22b. DATE SIGNED 25 Oct 66	
22c. PHYSICIAN'S NAME (Type) Herbert H. Leighton, M.D.		22d. ADDRESS Oakland, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/26/66	23c. NAME OF CEMETERY OR CREMATORIAL Oakland Cemetery
24. FUNERAL DIRECTOR John O. Durst		ADDRESS Leighton-Durst Funeral Home, Oakland, Md.	25a. REC'D BY REGISTRAR DATE OCT 28 1966
			25b. REGISTRAR'S SIGNATURE Charles Judge

2021

2021

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)									
a. COUNTY Garrett MARYLAND				a. STATE Md. b. COUNTY Garrett									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grantsville (Rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grantsville (Rural)									
c. LENGTH OF STAY IN 1b Life				d. STREET ADDRESS									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) George Otto Merrbach				First	Middle	Last	4. DATE OF DEATH Oct. 6, 1966	Month	Day	Year			
5. SEX M		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/1/1896	9. AGE (in years last birthday) 70 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Own Farm	11. BIRTHPLACE (County & State, or foreign country) Frostburg, Md.				12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME John Merrbach				14. MOTHER'S MAIDEN NAME Annie Bowers									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 217-09-9036	17. INFORMANT S. Francis Merrbach, R.D. Grantsville,	Address Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic Myocarditis, Non Rheumatic in origin</i> 4221 DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic heart disease</i> (c) <i>Generalized arteriosclerotic degenerative disease</i> INTERVAL BETWEEN ONSET AND DEATH 24 years													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>valvular insufficiency</i>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) R.D. Grantsville	(County) Garrett	(State) Md.					
21. I certify that (I) (this hospital) attended the deceased from 2-24, 1965, to 10-3, 1966, that (I) (we) last saw the deceased alive on 10-3, 1966, and that death occurred at 7:54 A.M. from the causes and on the date stated above.													
22a. SIGNATURE <i>Grant Atwell</i>				22b. DATE SIGNED 10-8-66									
22c. PHYSICIAN'S NAME (Type) Grant Atwell				22d. ADDRESS Meyersdale, Pa									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 10/9/66	23c. NAME OF CEMETERY OR CREMATORIAL Merrbach Cemetery	23d. LOCATION (City, town or county) R.D. Grantsville, Garrett, (State) Md.							
24. FUNERAL DIRECTOR Ruth E. Newman				ADDRESS Grantsville, Md.	25a. REC'D BY REGISTRAR OCT 11 1966	25b. REGISTRAR'S SIGNATURE Charles Judge							
VR A15 (4) 2DM 1/65													

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FOR STATE
HEALTH DEPT.

10 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

10 FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14200

1. PLACE OF DEATH a. COUNTY Garrett		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Barton		c. LENGTH OF STAY IN 1b Min.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Railroad			
3. NAME OF DECEASED (Type or print) WALTER SAMUEL NEAT		4. DATE OF DEATH OCT. 12 1966	Month Day Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Feb. 22, 1923
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) bar tender		10b. KIND OF BUSINESS OR INDUSTRY Tavern	
11. BIRTHPLACE (State or foreign country) Barton, Md.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Samuel Neat		14. MOTHER'S MAIDEN NAME Mary Brown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W. 2 214-16-2770	
17. INFORMANT RoseMary Neat-Barton, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 976X Conditions, If any, which gave rise to immediate cause (e), stating the underlying cause last. (b) (c) DUE TO Gunshot of Head Minutes (Self Inflicted)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and In my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>E. I. Baumgartner</i> EXAMINER'S NAME (Type) E. I. Baumgartner, M.D.			
CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 226 E. A 1/2 DR ST OAKLAND - MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/15/66	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Mt View		23d. LOCATION (City, town or county) (State) Moscow Mills, Md.	
24. FUNERAL DIRECTOR <i>E. I. Baumgartner</i>		25a. REC'D BY REGISTRAR DATE OCT 17 1966	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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1 M
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14201

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Garrett Co. Mem. Hospital		d. STREET ADDRESS Rt. 1	
3. NAME OF DECEASED (Type or print) First Oliver Middle Bliss Last Reams		4. DATE OF DEATH October 9 1966	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Bldg.	
13. FATHER'S NAME John Reams		14. MOTHER'S MAIDEN NAME Phila Lewis	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 220-16-5665	
17. INFORMANT Mrs. Cora Reams see #2 above		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 Min. 5 Min. Unknown	
Acute Peripheral Vascular Collapse		Acute Myocardial Infarct	
Arteriosclerotic Cardio-Vascular Disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Herbert H. Leighton</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
EXAMINER'S NAME (Type) Herbert H. Leighton, M.D.		22. DATE SIGNED 9 Oct 66	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/12/66	
23c. NAME OF CEMETERY OR CREMATORIUM Taylor-Sines Cemetery		23d. LOCATION (City or Town) (County) (State) Garrett Co. Md.	
24. FUNERAL DIRECTOR <i>Gerald D. Minnich</i>		ADDRESS Oakland, Maryland	
		25a. REC'D BY REGISTRAR DATE OCT 13 1966	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

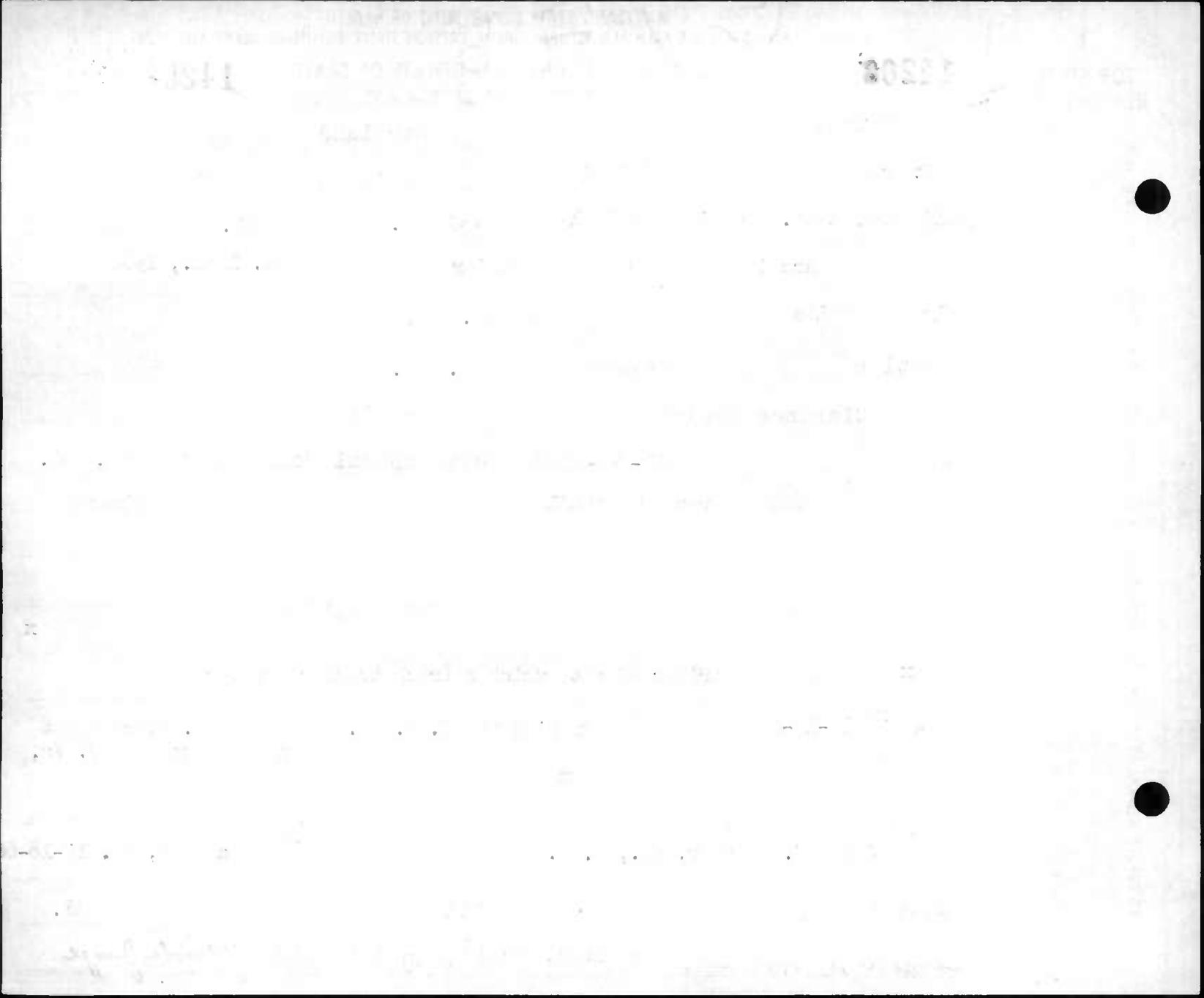
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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1, and give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PN3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

14202 MEDICAL EXAMINER'S CERTIFICATE OF DEATH **14202**

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if "institution: Residence before admission) a. STATE Maryland b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b Minutes		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) (DOA) Garrett Co. Memorial Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		
3. NAME OF DECEASED (Type or print) Archie		First C	Middle Rosier	
4. DATE OF DEATH Oct. 18th, 1966	Month Oct.	Day 18	Year 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH Mar. 12, 1926	
9. AGE (In years lost birthday) 40	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	
13. FATHER'S NAME Clarence Rosier	14. MOTHER'S MAIDEN NAME Lona Wilson	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		
16. SOCIAL SECURITY NO. 232-36-6505		17. INFORMANT Duda Funeral Home	Address Baltimore, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured skull DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) _____ DUE TO (c) _____				
INTERVAL BETWEEN ONSET AND DEATH Minutes				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)				
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Driver of auto which s truck tractor trailer		
20c. TIME OF INJURY Month, Day, Year Hour a.m. 10-18-66 p.m. 7		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office building, etc.) Highway U. S. Rt. 50 (Rural) Mt. Storm Grant	20f. (City or town) (County) (State) W. Va.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <i>James H. Feaster, Jr., M. D.</i>	M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	22. DATE SIGNED 10-18-66
EXAMINER'S NAME (Type) James H. Feaster, Jr., M. D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
Address (Street, city, town, or county) Oakland, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/24/66	23c. NAME OF CEMETERY OR CREMATORIUM Gardens of Faith	23d. LOCATION (City or Town) (County) (State) Baltimore	
24. FUNERAL DIRECTOR <i>Gerald N. Maxinch</i>	ADDRESS Oakland, Maryland	25a. REC'D BY REGISTRAR OCT 24 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



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FOR STATE
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14203

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14203

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File copies and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b Minutes				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) (DOA) Garrett Co. Mem. Hosp.		d. STREET ADDRESS 4314 E. Lombard St.				
3. NAME OF DECEASED (Type or print) Mickey Lee Rosier		First Mickey	Middle Lee			
Last Rosier		4. DATE OF DEATH Oct. 18th., 1966				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY School				
13. FATHER'S NAME Archie Rosier		11. BIRTHPLACE (State or foreign country) Maryland				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----				
17. INFORMANT Duda Funeral Home Baltimore, Md.		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed chest		INTERVAL BETWEEN DEATH AND DEATH Minutes				
816.1 Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) DUE TO (c)		DUE TO				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) In auto-tractor trailer accident, U. S. Rt. 50				
20c. TIME OF INJURY Month, Day, Year Hour 7 p.m. p.m. 10-18-66 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway	20f. (City or town) (Rural) Mt. Storm	(County) Grant	(State) W. Va.
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Nutrol causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) James H. Feaster, Jr., M. D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/24/66	23c. NAME OF CEMETERY OR CREMATORIAL Gardens of Faith	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.		
24. FUNERAL DIRECTOR Gerald D. Minnich		ADDRESS Oakland, Maryland		25a. RECD BY REGISTRAR DATE OCT 24 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14204

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14204

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b Minutes	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA) Garrett Co. Mem. Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Opal		First Marie	Middle Rosier
4. DATE OF DEATH Oct. 18th.		Month Oct.	Year 1966
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Mar. 26, 1931		9. AGE (In years last birthday) 35 yrs.	10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress		10b. KIND OF BUSINESS OR INDUSTRY Rest.	11. BIRTHPLACE (State or foreign country) W. Va.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Ray Sigley	
14. MOTHER'S MAIDEN NAME Bessie Wilmouth		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. 235-48-2734		17. INFORMANT Address Duda Funeral Home Baltimore, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured skull		INTERVAL BETWEEN ONSET AND DEATH Minutes	
816.1 Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in auto-tractor trailer accident	
20c. TIME OF INJURY Month, Day, Year Hour am. 7 10-18-66 p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway, U. S. Rt. 50 (rural) Mt. Storm, Grant,
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 10-18-66	
ACTUAL SIGNATURE <i>w. Feaster Jr.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.	
EXAMINER'S NAME (Type) James H. Feaster, Jr., M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Oakland, Md. 10-18-66	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/24/66	23c. NAME OF CEMETERY OR CREMATORIAL Gardens of Faith
23d. LOCATION (City or Town) Baltimore, Md.		(County) (State)	
24. FUNERAL DIRECTOR Gerald J. Minnich		ADDRESS Oakland, Maryland	25a. REC'D BY REGISTRAR OCT 24 1966
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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FOR STATE
HEALTH DEPT.

is necessary,
is forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files,
or used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14205

14205

1. PLACE OF DEATH a. COUNTY Garrett		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Frostburg		c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore											
d. STREET ADDRESS 9 Wells Avenue		d. STREET ADDRESS 9 Wells Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print) Wilfred		First Carl		Middle Simmons		4. DATE OF DEATH Last October Month 10 Day 1966		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/3/21		9. AGE (In years last birthday) 45 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0		11. IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.															
13. FATHER'S NAME Henry Carl Simmons		14. MOTHER'S MAIDEN NAME Mamie DuVall		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service) Unknown		16. SOCIAL SECURITY NO.		17. INFORMANT Floyd W. Simmons		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Self Inflicted Bullet wounds of skull DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 976X		b. with destruction of frontals, temporals and occipital bones Destruction Brain tissue		c. Result being shot by Jap 7.7 rifle		INTERVAL BETWEEN ONSET AND DEATH															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		20. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self inflicted injuries Jap 7.7 rifle		20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. Prob 10/10/66		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Woods		20f. (City or town) Rural Frostburg Garrett		(County) Md.		(State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/15/66		22c. NAME OF CEMETERY OR CREMATORIAL St. Lukes Cemetery		22d. LOCATION (City, town, or county) Cumberland, Md.		24e. REC'D BY REGISTRAR DATE OCT 17 1966		24b. REGISTRAR'S SIGNATURE Charles Judge		(State)							
23. FUNERAL DIRECTOR Philip B. Wendt 121 Memorial Ave. Cumb. Md.		ADDRESS																			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14206

CERTIFICATE OF DEATH

14206

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Garrett		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE West Virginia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		b. COUNTY Preston	
c. LENGTH OF STAY IN 1b 9 days-15½ hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aurora	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Garrett County Memorial Hospital		d. STREET ADDRESS 85-3	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Della	Middle Maude	Last Sims
4. DATE OF DEATH October 16, 1966	Month October	Day 16	Year 1966
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWWED <input checked="" type="checkbox"/> DIVDRCED <input type="checkbox"/>	8. DATE OF BIRTH October 17, 1892
9. AGE (In years last birthday) 73 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Aurora, West Virginia	
11. PLACE OF DEATH (State, or foreign country) Aurora, West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas A Lipscomb		14. MOTHER'S MAIDEN NAME Etta Bolyard	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 17. INFORMANT (Daughter) Mrs. Geo. Winters - Aurora, W. Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH Acute Myocardial Infarct 10 minutes Arteriosclerotic Cardiovascular Disease Unknown	
DUE TO (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May</u> , 1963 to <u>Oct 16</u> , 1966, that (I) (we) last saw the deceased alive on <u>Oct 15</u> , 1966, and that death occurred at <u>6:00 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>H. H. Leighton</u>		22b. DATE SIGNED 16 Oct 66	
22c. PHYSICIAN'S NAME (Type) Dr. H. H. Leighton		22d. ADDRESS Oakland, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 19, 1966	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Aurora Cemetery		23d. LOCATION (City, town or county) (State) Aurora, West Virginia	
24. FUNERAL DIRECTOR <u>Lester P. Hinkle Davis, W. Va.</u>		25a. REC'D BY REGISTRAR DATE OCT 18 1966	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1 14205 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.		14207 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Kitzmiller d. STREET ADDRESS Short Run Community e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
		1. PLACE OF DEATH a. COUNTY Garrett MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Deer Park 6 months c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.D. #1 - (Eagle Rock)		3. NAME OF DECEASED (Type or print) Cassie Victoria Susan Wilson First Cassie Middle Victoria Last Susan Month Oct. Dey 15 Year 19 66		4. DATE OF DEATH Oct. 5, 1882		5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 5, 1882		9. AGE (In years last birthday) 84 yrs. 10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Garrett Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME James Hezekiah Wilson		14. MOTHER'S MAIDEN NAME Mary Margaret Harvey											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Mrs. Ruth Upperman, R#1, Deer Park, Md.		Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						INTERVAL BETWEEN ONSET AND DEATH 4 yrs. 6-8 yrs.							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) Arteriosclerosis Diabetes Mellitus											
DUE TO (c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on....., 19....., and that death occurred at....., 19....., from the causes and on the date stated above.													
22e. SIGNATURE A. E. Mance		M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 16 Oct 66							
22c. PHYSICIAN'S NAME (Type) Dr. A. E. Mance				22d. ADDRESS Oakland, Md. 21550									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 18/66		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Short Run Cemetery Blaine, W. Va.		23d. LOCATION (City, town or county) Kitzmiller, Garrett Co., Md.							
24. FUNERAL DIRECTOR'S SIGNATURE Amy Mildred Sharpless				25a. REC'D BY REGISTRAR DATE OCT 24 1966		25b. REGISTRAR'S SIGNATURE Charles Judge							

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 14205
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14208

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Garrett</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>MD</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Kitzmillier</i>		b. COUNTY <i>Garrett</i>	
c. LENGTH OF STAY IN 1b <i>5</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Kitzmillier</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>00</i>		d. STREET ADDRESS <i>11-1</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Wendell (nm)</i>	Middle <i></i>	Last <i>Wilson</i>
4. DATE OF DEATH	Month <i>October</i>	Day <i>12</i>	Year <i>1966</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>3-3-1903</i>
9. AGE (in years last birthday) <i>63</i>	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS. Days <i></i>	12. IF UNDER 24 HRS. Hours <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Trucker</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>General trucking</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Kitzmillier, MD</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>John A. Wilson</i>	14. MOTHER'S MAIDEN NAME <i>Minnie Paugh</i>	Address <i>Kitzmillier, MD</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>216-03-4604</i>	17. INFORMANT <i>Minnie P. Wilson</i>	18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <i>4201</i> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) DUE TO (c) COPING COPING ITSELF DOWN INTERVAL BETWEEN ONSET AND DEATH <i>Second and 12yrs</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)			
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OP. CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		
20c. TIME OF INJURY Hour e.m. p.m. <i>19</i>	20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Kitzmillier</i>	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from..... saw the deceased alive on..... and that death occurred at... M, from the causes and on the date stated above.	22b. DATE SIGNED <i>Oct. 14, 66</i>		
22e. SIGNATURE <i>Ralph Calandella</i>	22d. ADDRESS <i>Kitzmillier, MD</i>		
22e. PHYSICIAN'S NAME (Type) <i>Ralph Calandella</i>	M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>10-15-66</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Westview Hill Cemetery</i>	23d. LOCATION (City, town or county) (State) <i>EIK Garden WVa.</i>
24 FUNERAL DIRECTOR'S SIGNATURE <i>Robert Kyle Pulte Jr.</i>	ADDRESS <i>Kitzmillier, MD.</i>	25e. REC'D BY REGISTRAR DATE <i>OCT 17 1966</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14209

14209

CERTIFICATE OF DEATH

Items 3,9 Film 6381 10/13/66 ph

1. PLACE OF DEATH

a. COUNTY

Garrett

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Oakland

c. LENGTH OF STAY IN 1b

14 Days

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Garrett County Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)

a. STATE

W.Va.

b. COUNTY

Tucker

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Thomas

853

d. STREET ADDRESS

Box 205

e. IS RESIDENCE
ON A FARM?YES NO 3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATHMonth
October
5Day
19
66

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

9. AGE (In years
last birthday)

10. UNDER 1 YEAR

11. UNDER 24 HRS.

Male

White

WIDOWED

DIVORCED

November 1, 1891

1074 yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)10b. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

12. CITIZEN OF WHAT
COUNTRY?

Coal Miner Ret.

Coal

Location, W.Va.

America

13. FATHER'S NAME

John C. Wotring

14. MOTHER'S MAIDEN NAME

Elizabeth Nestor

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

232-03-1399

Julia C. Wotring, Thomas, W.Va.

Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

331X

DUE TO

Conditions, If any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO

(c)

Cerebral Hemorrhage

INTERVAL BETWEEN
ONSET AND DEATH

10 days

Ruptured Sclerotic

1 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 20d. INJURY OCCURRED
p.m. 19 While Not While
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 9/21, 1964 to Oct 6, 1966, that (I) (we) last
saw the deceased alive on Oct. 5, 1966, and that death occurred at 6:30 AM, from the causes and on the date stated above.

22a. SIGNATURE

A. E. Mance

22b. DATE SIGNED

6 Oct 66

22c. PHYSICIAN'S
NAME (Type)

Dr. A. E. Mance

ATTENDING
M.D.
PHYS.MED.
DIRECTORSTAFF
PHYS.

22d. ADDRESS

Oakland, Maryland

23a. BURIAL, CREMATION,
REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORIAL
Burial 10/8/66 Rose Hill Cem.23d. LOCATION (City, town or county) (State)
Thomas, W.Va.

24. FUNERAL DIRECTOR ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

G. D. Duncane

Thomas, W.Va.

DATE OCT 10 1966

Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

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To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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14210 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH
14210

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b 15 hrs. 5 mins.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Garrett County Memorial		d. STREET ADDRESS 301 Oakland Dr.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Ernest	Middle Sherman	Last Wotring
4. DATE OF DEATH October 27, 1966	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH August 31, 1885
9. AGE (in years last birthday) 81	10. UNDERTAKER 1 YEAR Months 11	11. UNDERTAKER 24 HRS. Days 1	12. IS RESIDENCE ON A FARM? Hours 1 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Master Contractor	10b. KIND OF BUSINESS OR INDUSTRY Building	11. BIRTHPLACE (County & State, or foreign country) Aurora, W. Va.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Newton Wotring	14. MOTHER'S MAIDEN NAME Lydia King		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. 214-16-2579	17. INFORMANT Robert Wotring, Oakland, Md. (Son)	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5810 DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO Chromia - Severe jaundice Cirrhosis of Liver INTERVAL BETWEEN ONSET AND DEATH 3 months 5 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Coronary Artery Disease - Advanced			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March 1958 to Oct 27, 1966 , that (I) (we) last saw the deceased alive on Oct. 26, 1966 , and that death occurred at 12:35 AM , from the causes and on the date stated above.			
22a. SIGNATURE Dr. H. H. Leighton	22b. DATE SIGNED 27 Oct 66		
22c. PHYSICIAN'S NAME (Type) Dr. H. H. Leighton	22d. ADDRESS Oakland, Maryland		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/29/66	23c. NAME OF CEMETERY OR CREMATORIAL Aurora Cemetery	23d. LOCATION (city, town or county) (State) Aurora, W. Va.
24. FUNERAL DIRECTOR John O. Durst	25a. ADDRESS Leighton-Durst Funeral Home, Oakland, Md.	25b. REC'D BY REGISTRAR OCT 31 1966	25c. REGISTRAR'S SIGNATURE John O. Durst

FOR STATE
HEALTH DEPT.

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14211
10 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

10 FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14211

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland, Md.		c. LENGTH OF STAY IN 1b 40 minutes	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Garrett Co. Mem. Hospital		d. STREET ADDRESS 233 W. Liberty St.	
3. NAME OF DECEASED (Type or print) George Harold Yutzy		First George	Middle Harold
3. NAME OF DECEASED (Type or print) George Harold Yutzy		Last Yutzy	4. DATE OF DEATH October 2nd. 1966
S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/> <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/> <input checked="" type="checkbox"/>
8. DATE OF BIRTH 6-1-09		9. AGE (In years last birthday) 57 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant		10b. KIND OF BUSINESS OR INDUSTRY Business	
11. BIRTHPLACE (State or foreign country) Crellin, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Yutzy		14. MOTHER'S MAIDEN NAME Maude Sanders	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 235-22-4210	
17. INFORMANT Mrs. G. Harold Yutzy see # 2 above		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular hemorrhage, massive		INTERVAL BETWEEN ONSET AND DEATH 2 hrs.	
331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension		Years	
DUE TO DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>James H. Foaster, Jr., M.D.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Oakland, Md.	
EXAMINER'S NAME (Type) James H. Foaster, Jr., M.D.		22. DATE SIGNED 10-2-66	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/5/66	
23c. NAME OF CEMETERY OR CREMATORIAL Garrett Co. Mem. Gardens		23d. LOCATION (City or Town) (County) (State) Oakland, Maryland	
24. FUNERAL DIRECTOR Leveld J. Minnich		ADDRESS Oakland, Maryland	25a. REC'D BY REGISTRAR OCT 10 1966
			25b. REGISTRAR'S SIGNATURE Charles Judge

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